STATUS 15 Jan 2016: FINAL!

Coca Derivatives and Consumer Countries

Luca Di Censi, Francesco Fabi and Carla Rossi[1]

Abstract

Cocaine is a powerful stimulant drug extracted from the leaves of the coca plant. Crack is a form of cocaine that has been processed to produce crystals (also called 'freebase cocaine' or 'rocks') that can be smoked. Cocaine and crack are strong but short-acting stimulant drugs. They tend to make users feel more alert and energetic.

The prevalence of cocaine consumption in the world is quite high. Cocaine addicts are estimated at about 18 million (0.4% of the adult population). Cocaine is the second most used illegal drug in the world. In European countries, the EMCDDA reports a prevalence of 1.9% in the 15-34 age group, ranging from 1% in Finland to 4.2% in the UK. In the United States the prevalence of use in the last 12 months is 1.8% (stable) in the general population and 5.4% (increasing) among young people (18-25).

Using data about seizures in various countries, it is possible to analyse the different trafficking routes in recent years. These routes explain the spread of cocaine consumption in West Africa, Eastern Europe and, recently, in Oceania, together with related phenomena such as criminality and corruption.

This chapter analyse the different 'populations' involved (consumers, dealers, traffickers, etc) presenting worldwide available reliable data.

Keywords: crack-cocaine, consumption, trafficking, routes, drug seizures

Introduction

Cocaine is a powerful stimulant drug made from the leaves of the coca plant. Crack is a form of cocaine that has been processed to produce crystals (also called 'freebase cocaine' or 'rocks') that can be smoked.

Cocaine and crack are strong but short-acting stimulant drugs. They tend to make users feel more alert and energetic. Many users say they feel very confident and physically strong and believe they have great mental capacities. Common physical side effects include dry mouth, sweating, loss of appetite and increased heart and pulse rate. At higher dose levels, users may feel very anxious and panicky. The effects from snorting cocaine (taking it in through the nose) usually set in quickly but only last for up to 30 minutes, if the intake is not repeated. The effects of smoking crack set in even quicker but are not as long lasting.

Because of cocaine's high cost, it has long been considered a 'rich man's drug'. Crack, on the other hand, is sold at lower prices that even teens can afford – at first. The truth is that once a

[1] Associazione Centro Studi Statistici e Sociali, Rome, Italy (http://www.ce3s.eu/).

person is addicted, the expense skyrockets in direct proportion to the increasing amount needed to support the habit.

For both crack and cocaine, dependency is not inevitable. Whether people become dependent, and if so how quickly it happens, will vary depending on the individual user's mental state and circumstances. The fact that cocaine and crack are expensive means that people who become dependent may spend vast amounts of money. Those who are not wealthy may find themselves involved in crime or prostitution to finance the habit.

The negative effects of crack are stronger than those of cocaine, as recognised by Nutt et al. (2008, 2010) and van Amsterdam et al. (2010, 2013). In a recent paper (Mammone et al. 2014), a new 'risk of harm' indicator has been derived, combining previous ones. It measures the harm to the user population in order to compare unintended consequences of drug policy in different countries. The harm indicator value for cocaine is 2.07 and for crack 2.67, 29% higher (for the purposes of comparison, the value for heroin is 2.51, for alcohol 2.18 and for cannabis 1.18).

There are similarities between the spread of drug use, in particular the spread of use of addictive drugs, and that of infectious diseases, as described since 1969 with respect to heroin (de Alarcón 1969, Mackintosh and Stewart 1979, Hunt and Chambers 1976). The use of drugs is communicated as a kind of 'innovative' social practice or custom, and not to everyone but only to those who, for whatever reason, are not immune (susceptible individuals). Once the contagious nature of drug use is accepted, the epidemiological concepts of 'incidence' (the rate of new cases occurring within a certain period of time) and 'prevalence' (the number of cases at a particular time) are operationally valuable in studying the diffusion and dynamics of illegal drug use (Rossi 2002), in this case regarding coca derivatives.

Cocaine diffusion in consumer countries

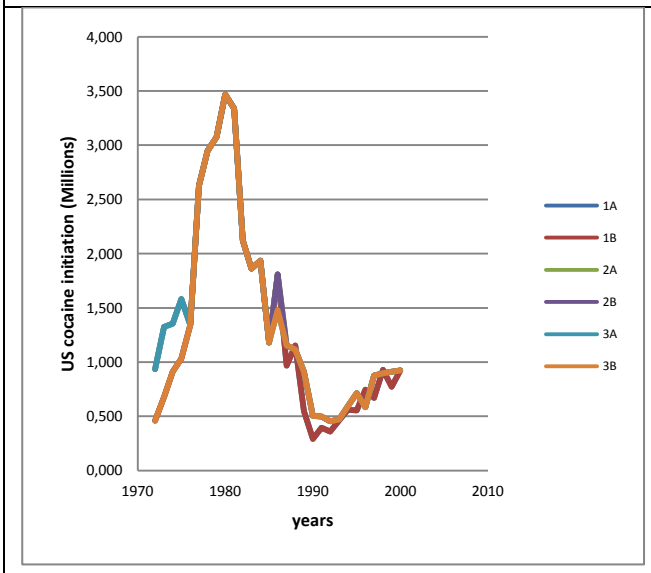
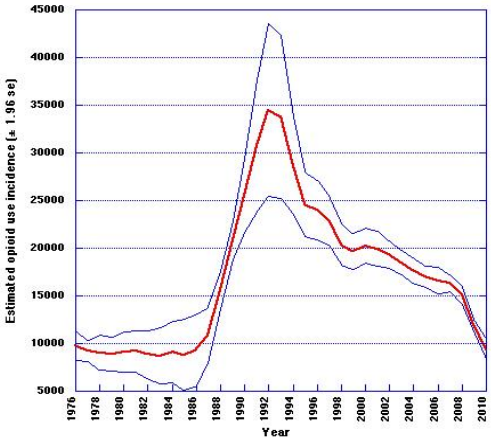
Peter Reuter described the cocaine epidemic(s) in the US quite efficiently in 2001. In Europe and other countries, the spread took place some years later than in the US, due to the expansion of drug trafficking and drug routes.

> *"Drug epidemics (…) are characterized by sharp peaks in population incidence rates followed, with a lag, by a plateauing at a new high in the number of dependent users. The pattern reflects the fact that a portion of new users become dependent within a few years, that incidence is partly driven by the extent of perceived problematic use and that exit from dependence is slow. Everingham and Rydell (1994) offer a now classic representation of that phenomenon, while Behrens and others (1999, 2000) have explored the dynamics in more detail. Drug markets vary over the course of a drug epidemic in the ratio of heavy users to light users, the mean age of users and, in a predictable fashion, the opportunity cost of sellers' time. Those in turn affect the level of property crime generated by drug use.*
>
> *In the early stages of the cocaine epidemic in the United States, drug users were not predominantly poor. The image of the drug was relatively benign, its dangers were little known and its attractions were great. Most users were inexperienced and did not at that time consume large quantities or suffer significant problems. Low-income users could earn substantial incomes selling to users who are not poor. Such conditions are likely to be common in the early stages of drug epidemics in which the drugs are not well known to the population.*

> *In the late 1980s, frequent users made up a much larger fraction of all cocaine users and accounted for a larger fraction of total cocaine consumption. Cocaine users were then poorer and had acquired both a criminal history and a record of treatment. More educated cocaine users were likely to have responded to messages about the adverse consequences of the drug and to experience better outcomes in treatment. Evidence from the National Household Survey on Drug Abuse shows that the negative correlation of current cocaine use (that is, use in the previous month) and education increased substantially after 1985 (Reuter et al. 1994)."* (Reuter 2001)

Figure 1 shows the typical behaviour of epidemic incidence curves. The first one is related to the cocaine epidemic in the US according to Caulkins at al. (2004) and the second one to the heroin epidemic in Italy (EMCDDA 2012). The heroin epidemic in Italy has been decreasing and, after the endemic stage, is presently (since 2013) increasing towards the second epidemic wave, as the US cocaine epidemic that is presently increasing among young people towards a second epidemic stage.

Figure 1. Examples of incidence curves in drug epidemics

Incidence curves estimated with different hypotheses	Heroin incidence curve estimated in Italy by Back-calculation
	
Source: Table 2 in Caulkins et al. 2004	Source: EMCDDA 2012

Prices

Drugs are sold in illegal markets. The prices are determined systematically: notwithstanding the high rate of observed variation, they have clear patterns. Moreover, those prices have important implications both for participants (users and dealers) and for others, including potential users (because prices affect the incentive to start using drugs) and society more generally (through crime and the generation of criminal income).

Cocaine prices in consumer countries can be found in UNODC site[2] and the behaviours in the period 1990-2014 are presented in Figure 2 (a and b) for Western Europe and US.

In Figure 2 b the decreasing behaviour is evident, showing that the actual drug laws and policies are not effective in winning the crime organization power on drug trafficking, in particular on cocaine market[3].

Figure 2 a. Cocaine prices in Western Europe and in the USA in current currency units, 1990-2014

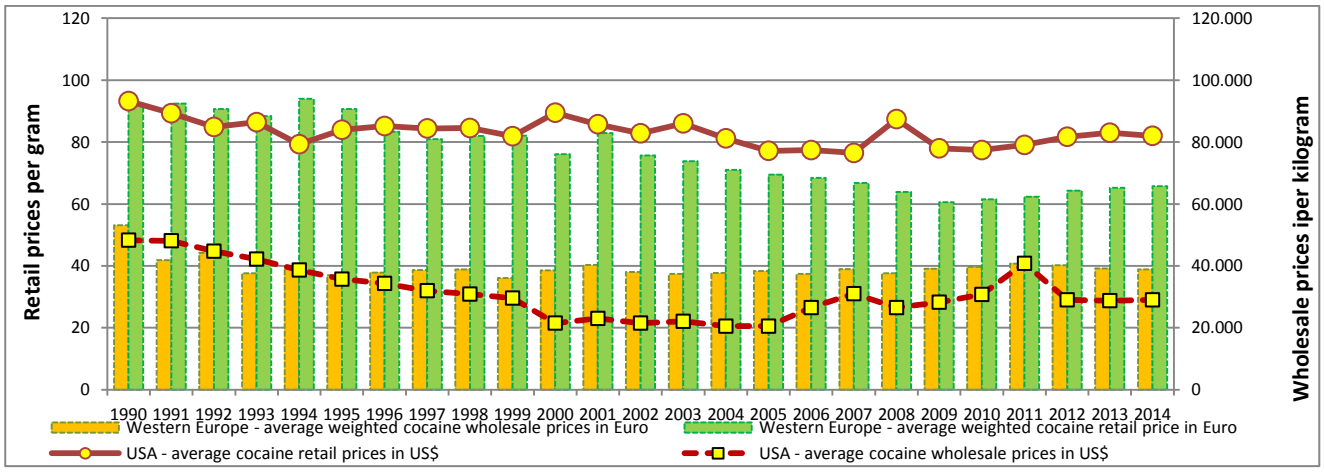
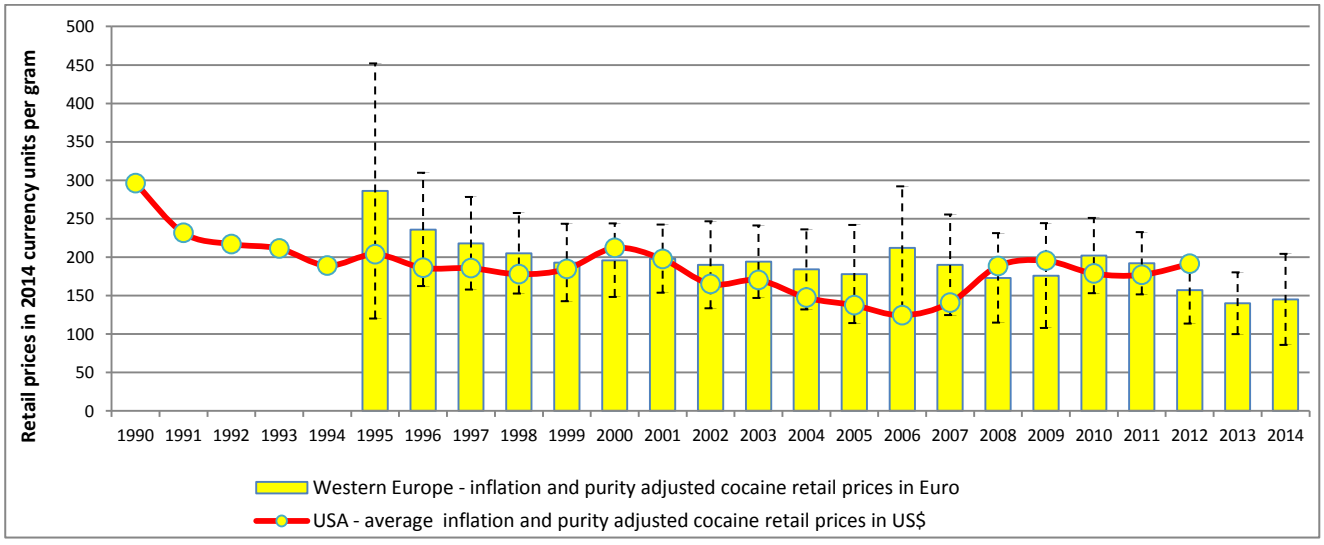


Figure 2 b. Purity adjusted cocaine retail prices in Western Europe and USA in constant 2014 currency units, 1990-2014



Sources: UNODC calculations based on UNODC, ARQ data, EMCDDA, Statistical Bulletin 2016 , ONDCP, 2015 National Drug Control Strategy - 2015 Data Supplement, UN DESA, Population Division, World Population Prospects, the 2015 Revision, Eurostat, Consumer prices and Bureau of Labor Statistics, Historical Consumer Price Index.

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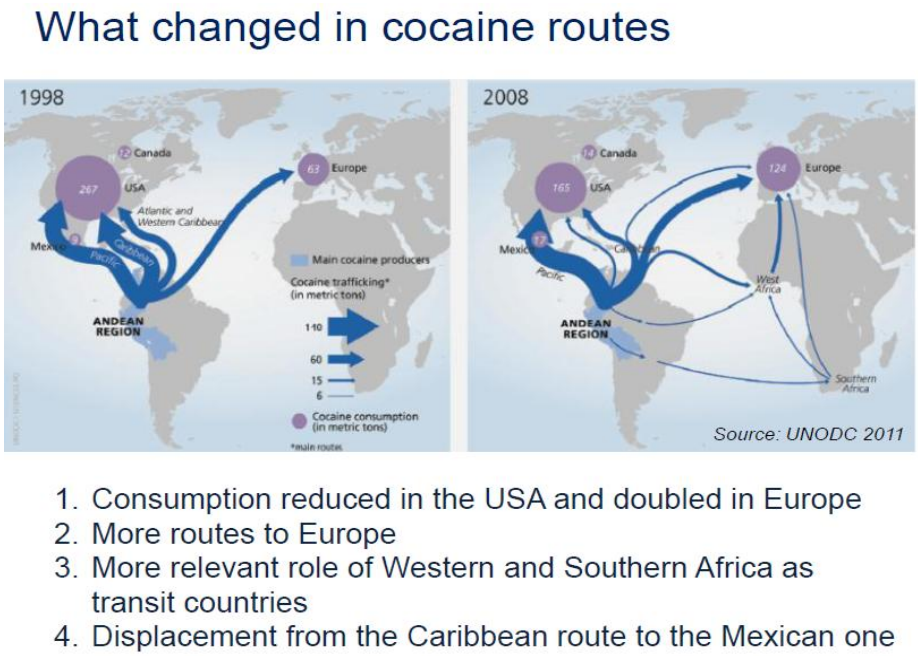
http://www.unodc.org/unodc/search.html?q=cocaine+prices&site=unodc&btnG=Search&site=unodc&proxyreload=1&sort=date%3AD%3AL%3Ad1&entqr=0&entqrm=0&ud=1

3 Cocaine trafficking to Europe is conducted by organised crime groups that are characterised by diversity and adaptability. These groups are innovative and skilled in switching and modifying both trafficking routes and modi operandi to circumvent law enforcement activities. They are quick to identify and exploit new opportunities for cocaine trafficking. This includes taking advantage of new technology and methods to facilitate access to maritime containers loaded with cocaine (e.g. rip-on/rip-off) and for concealing cocaine (e.g. incorporating liquid cocaine into materials for later extraction). In addition OCGs also shift transit routes and storage points to capitalise on the presence of ineffective border controls, and areas where instability and poor governance make for weak law enforcement. http://www.emcdda.europa.eu/topics/pods/cocaine-trafficking-to-europe.

Supply routes

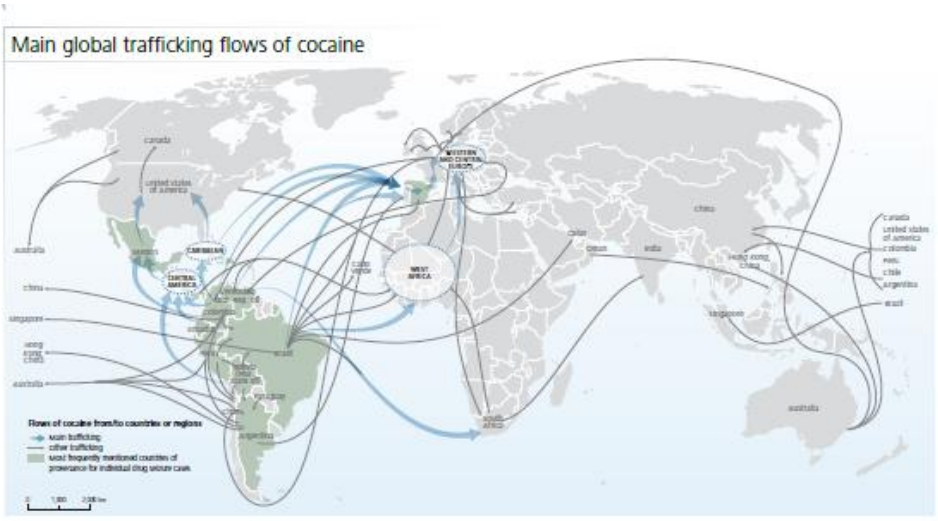
To understand the spread of cocaine use in the world, it is basic to know the evolution of the routes used by traffickers from supply countries to consumer countries. These routes are shown in Figure 3 (a and b).

Figure 3 a. Cocaine routes in 1998 and 2008



Source: UNODC. Presentation by Sandeep Chawla and Angela Me, “Challenges in estimating the production of pure cocaine HCl,” at the EU Conference “Improving responses to organised crime and drug trafficking along the cocaine route,” Rome, 28-30 May 2013.

Figure 3 b. Cocaine routes reported in the UNODC World Drug Report 2015



Source: UNODC, responses to annual report questionnaire and individual drug seizure database.

Notes: The trafficking routes represented on this map should be considered broadly indicative and based on data analyses rather than definitive route outlines. Such analyses are based on data related to official drug seizures along the trafficking routes as well as official country reports and responses to annual report questionnaires. Routes may deviate to other countries that lie along the routes and there are numerous secondary flows that may not be reflected.

The boundaries shown on this map do not imply official endorsement or acceptance by the United Nations. Dashed lines represent undetermined boundaries. The dotted line represents approximately the Line of Control in Jammu and Kashmir agreed upon by India and Pakistan. The final status of Jammu and Kashmir has not yet been agreed upon by the parties. The final boundary between the Sudan and South Sudan has not yet been determined.

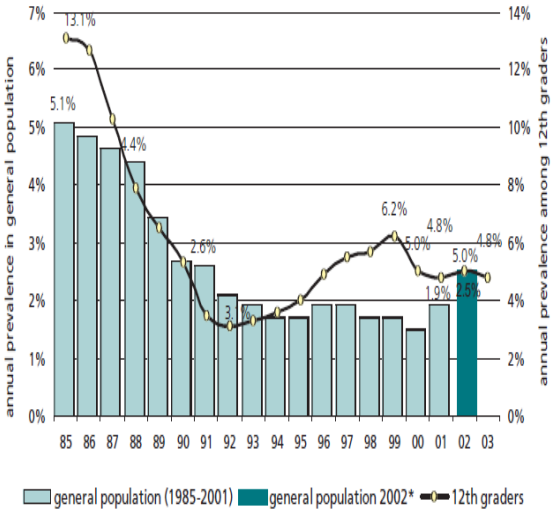
The first routes to Europe ran directly from Central and South America to the United Kingdom and the Iberian Peninsula. In Europe, the 'epidemics' developed starting in the UK and Spain due to the direct influence of the supply routes. New routes now pass through Africa, arriving from South America to West Africa and then towards the Mediterranean to Spain, Italy and other countries, such as the Balkans. A specific route goes directly to South Africa and then to South Asia and Oceania. In the last decade the Oceania cocaine market doubled, in particular in Australia (UNODC World Drug Report 2016).

Diffusion of cocaine and crack in North America (US and Canada)

Most Americans first learned about crack cocaine through media stories, which usually disclosed tragic details of public figures' addictions. Coverage of the dangers associated with the use of all forms of cocaine intensified in 1979 with the emergence of the practice of smoking cocaine, colloquially referred to as 'freebasing'. In 1985, *The New York Times* became the first major media outlet to use the term 'crack cocaine', and a follow-up article appeared on the front page detailing crack cocaine and its intensely addictive quality. By 1986, major news outlets had declared crack cocaine usage to be in "epidemic proportions" (Beaver 2010).

The prevalence of cocaine users in the US is shown in Figure 4. The epidemic character of the use of a specific drug, in this case cocaine, implies that after the initial epidemic stage an endemic one starts lasting for many years, after which another, 'lower' epidemic stage can follow, as it is happening in US and Europe in recent years with respect to heroin.

Figure 4. Cocaine use annual prevalence among various populations in the US



Cocaine use in the USA: 1985-2002 annual prevalence rates among the general population, age 12 years and above, and among high-school students (12th graders).

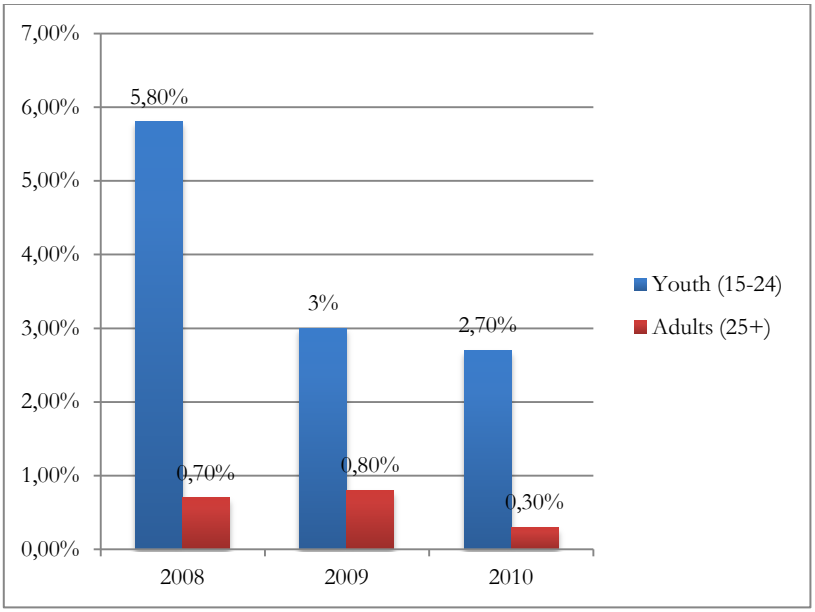
* Given changes in the methodology used, general household survey data for 2002 are not comparable with results of previous surveys conducted in previous years.

Sources: SAMHSA, results from the 2002 National Survey on Drug Use and Health and previous National Household Surveys on Drug Abuse; NIDA, Monitoring the Future, 2002 and previous years.

Several tables are available for the following years showing that cocaine annual consumption among persons aged 12 or older are waving around 1.9%, showing the endemic behaviour[4] in the general population. Similar behaviour can be observed in Canada, as shown in Figure 5.

[4] https://www.samhsa.gov/data/sites/default/files/NSDUH-DetTabsPDFWHTML2013/Web/PDFW/NSDUH-DetTabsSect7peTabs1to21-2013.pdf, https://www.samhsa.gov/data/sites/default/files/NSDUH-DetTabs-2015/NSDUH-DetTabs-2015/NSDUH-DetTabs-2015.htm#tab1-1b).

Figure 5. Prevalence of past-year cocaine use in Canada (2008, 2009, 2010)



Source: Canadian Alcohol and Other Drug Use Monitoring Survey (CADUMS) 2008, 2009, 2010

In 2011 and 2012 past-year prevalence, just for adult population, is available in Canada showing an increasing behaviour: prevalence: 0.7 for both years[5].

Trends in cocaine use in the UK

The prevalence of cocaine use in the UK steadily increased in the 1990s and 2000s and, though recent indications suggest that the trend has stabilised, use in the UK remains the highest in Europe, along with Spain. In 1996, 0.6% of 16 to 59 year olds had tried the drug in the last year. This proportion increased to 3% in 2008-09 and then decreased to 2.5% in 2009-10 and to 2.2% in 2014[6].

As on the continent, cocaine is the UK's second most used illicit substance after cannabis and, as with cannabis, there is a considerable diversity among its users. There are occasional recreational users as well as dependent and marginalised users.

The average profile of the members of the first group includes stable living conditions and regular employment. Cocaine is used in its powder form, alone or in combination with other substances (except heroin), on a weekly basis.

The second group has a more socially disadvantaged profile, usually using either crack cocaine or the combination of cocaine and heroin. Crack users commonly live in large cities, often belong to ethnic minorities, and many of them are unemployed and have precarious living conditions.

[5] http://www.hc-sc.gc.ca/hc-ps/drugs-drogues/stat/_2012/tables-tableaux-eng.php#t4.

[6] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/462885/drug-misuse-1415.pdf.

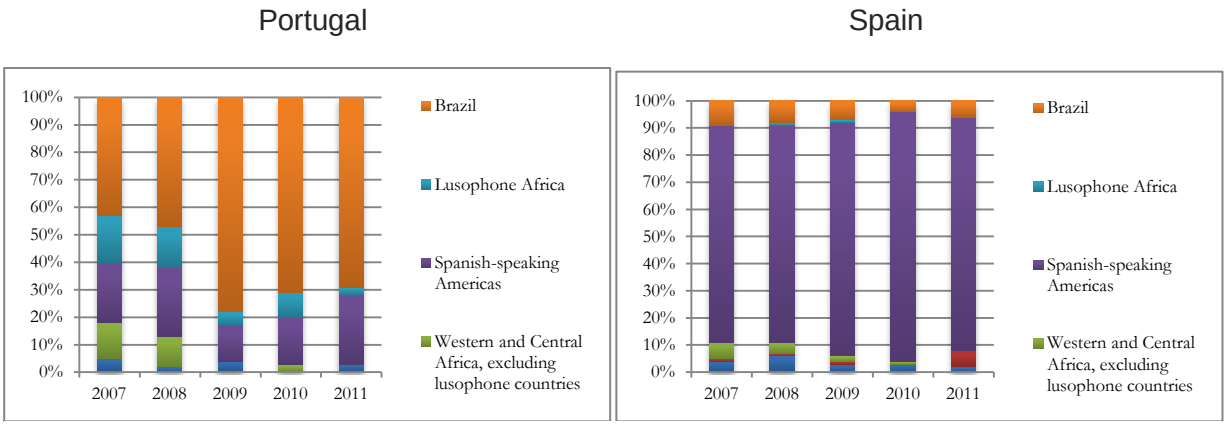
The Iberian Peninsula as the main importing region for the rest of Europe

Spanish cocaine seizures primarily take place in international waters. About one tenth is found in shipping containers. A much smaller share (2%) is seized close to the country's beaches, while airports account for just 6%. Portuguese seizures basically mirror the patterns seen in Spain, showing increases until 2006 and declines thereafter. The changes have been even more pronounced in Portugal, reflecting the strong links with trafficking via West Africa (Guinea-Bissau and Cape Verde).

Trafficking of cocaine to Europe is, to a significant extent, run by Colombian organised crime groups that forge alliances with various criminal groups operating in Europe, notably groups in Spain, Italy and the Netherlands. In most European countries, the majority of those arrested for drug trafficking are local citizens, but the Colombian groups act as importers and, to a lesser extent, as wholesalers. Other South Americans are also prominent, especially on the Iberian Peninsula. In a number of countries in continental Europe West Africans are active as retailers, as well as small-scale importers.

A few groups from the Balkan region have also emerged as players in the international cocaine trade in recent years. In contrast, there is little concrete evidence so far to suggest that the Mexican drug cartels are playing a major role in Europe. As for the countries of provenance of individual seizures in the Iberian Peninsula, there are quite large differences between Spain and Portugal, as clearly shown in Figure 6. In particular the link between Portugal and Brazil is evident.

Figure 6. Countries of provenance of cocaine seized in Portugal and Spain (2007-2011)



Source: UNODC, individual drug seizure database.

Note: Reporting countries are asked to provide information about the country where the drugs were obtained (or, in the case of unaccompanied shipments, the departure country). For the purposes of this figure, this is considered as the provenance of the drug. However, countries are also asked to provide information on the country of origin, i.e., where the drugs were produced/manufactured. In cases where the country where the drugs were obtained is not specified, or coincides with the country that made the seizure, the country of origin is taken as the provenance. In order to reflect patterns in transnational trafficking, any cases where the provenance coincides with the country making the seizure, or where no information on provenance is known, are excluded.

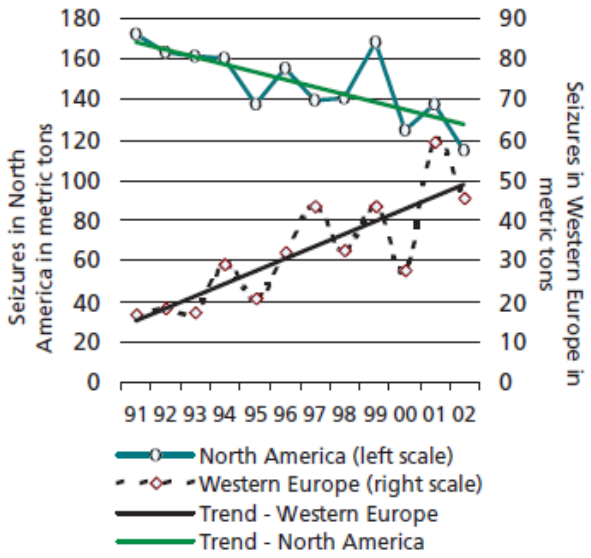
Trends in cocaine use in Western Europe and other parts of the world

Cocaine use has spread in Western Europe and is still spreading to other European countries, in particular Eastern Europe, as shown in Figure 7, Figure 8 and Figure 9.

In Figure 8 it is clear that the first European countries of cocaine use (Spain and UK) show decreasing but higher prevalence trends whereas the other countries show increasing trends.

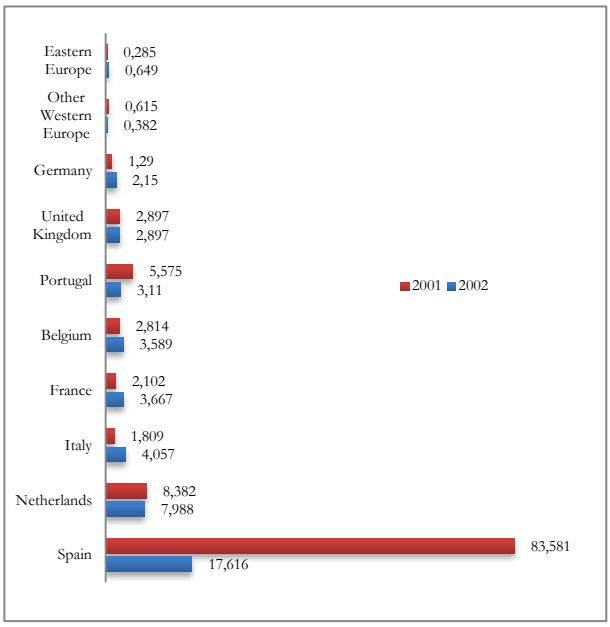
Figure 7. Trends in cocaine seizures in the US and Europe

Cocaine seizures: North America and Western Europe



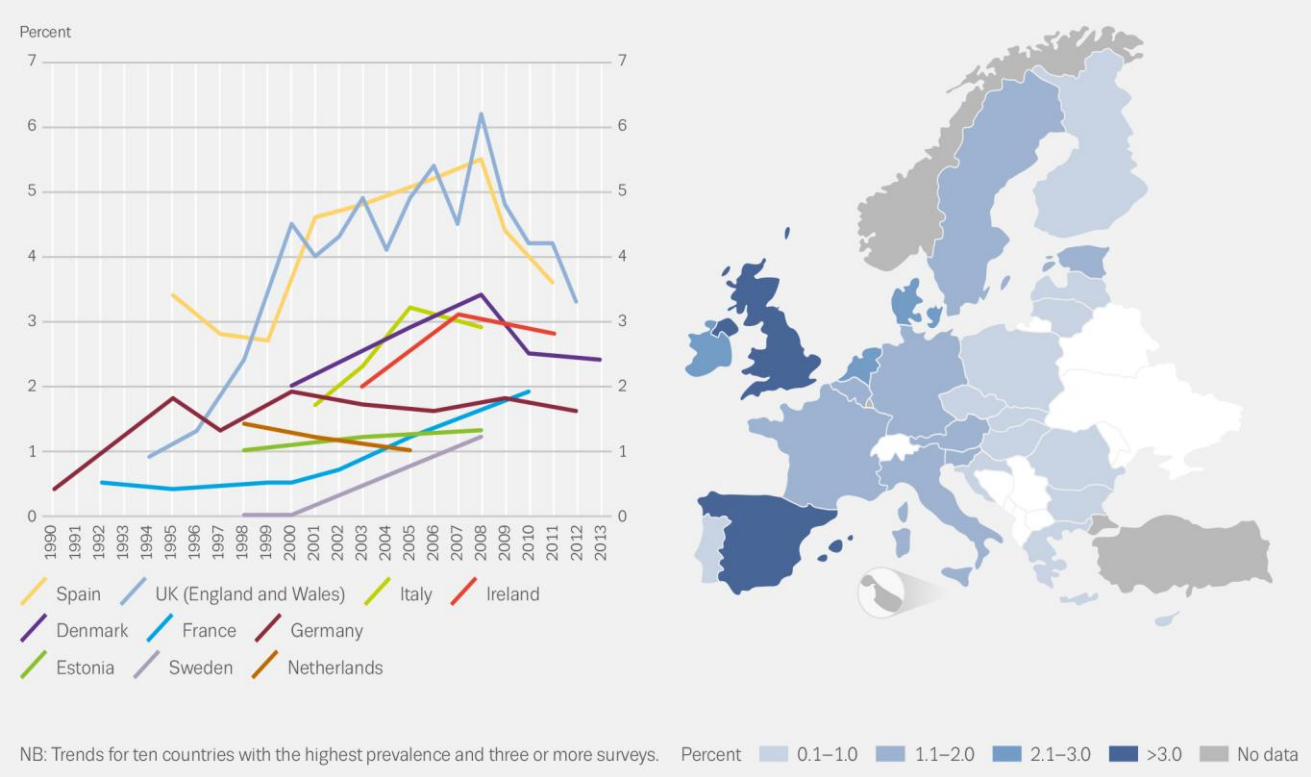
Source: UNODC, Annual Reports Questionnaire Data

Cocaine seizures in Europe in 2001 and 2002



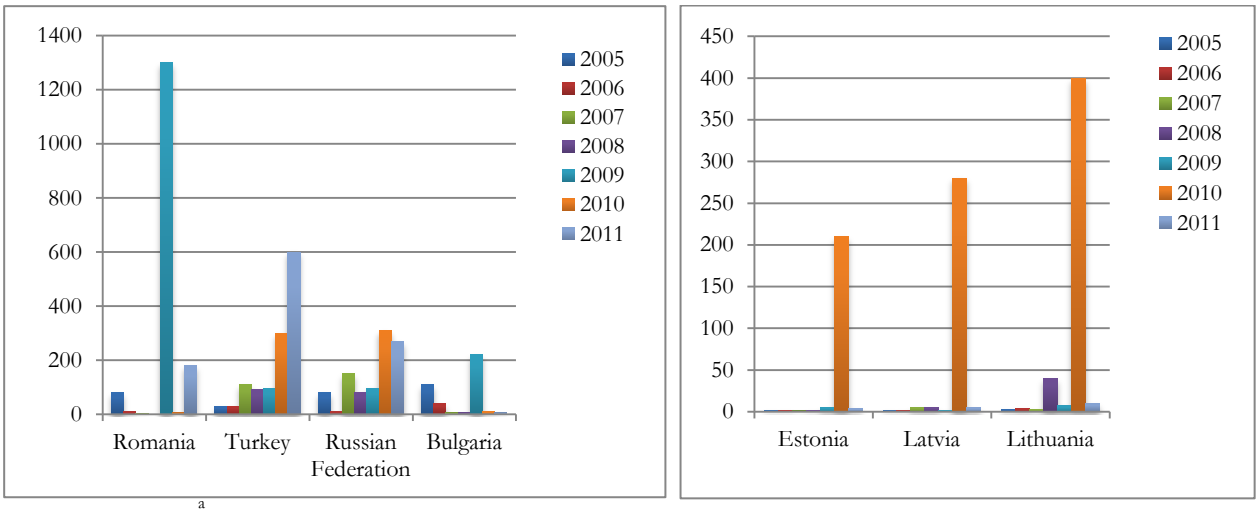
Source: UNODC, Annual Reports Questionnaire Data/DELTA

Figure 8. Last year prevalence of cocaine use among young adults (15-34): selected trends (left) and recent data (right) in the EU



Source: EMCDDA 2014

Figure 9. Cocaine spread in new European countries

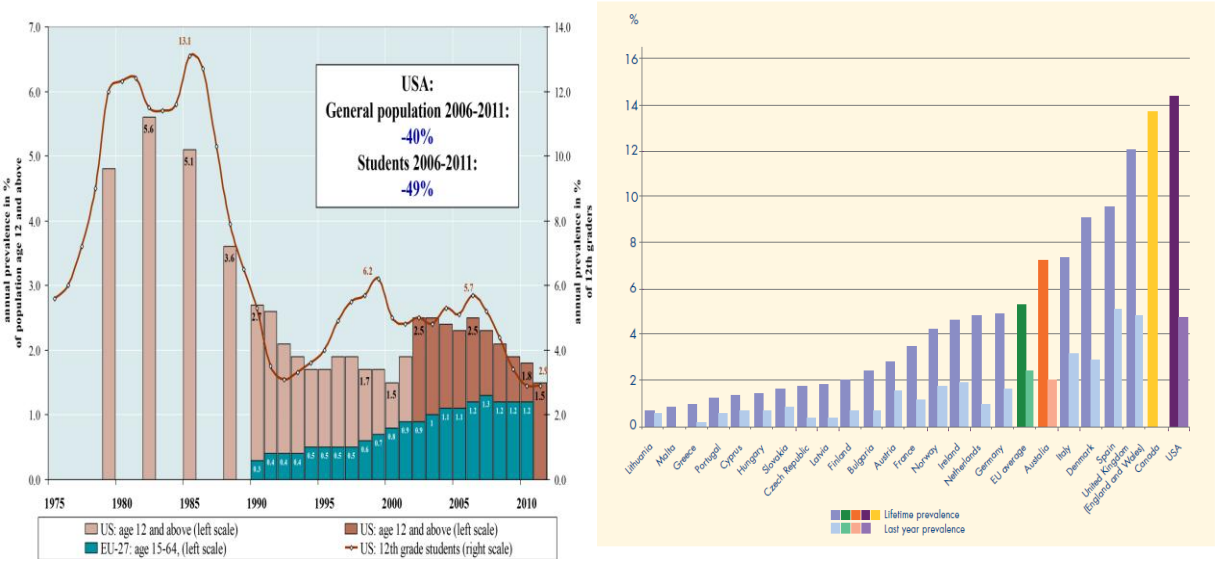


[a] the high level of seizures in Romania in 2009 was mainly due to a single large seizure in the port of Constanta.

Source: UNODC, data from Annual Reports Questionnaire and other official sources

As a final synthesis, Figure 10 shows the cocaine use epidemics in the US and Europe. Differences in start dates and prevalence levels are clearly visible.

Figure 10. Cocaine use prevalence in the US, Canada and Europe



Sources: SAMHSA, National Household Survey on Drug Use and Health 2011; NIDA, Monitoring the Future, 2011; UNODC, Annual Reports Questionnaire data; EMCDDA, Statistical Bulletin (2011 and previous years)

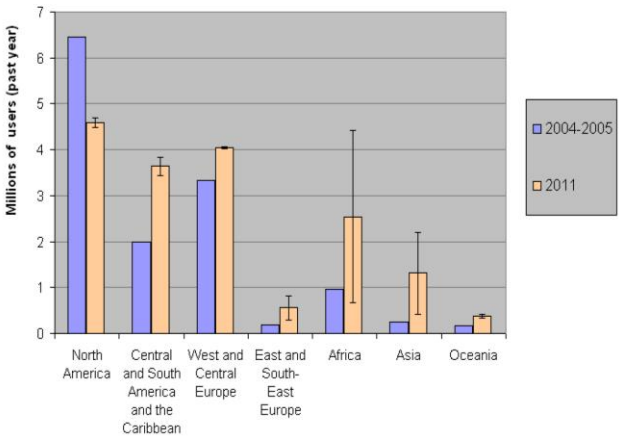
Epidemic behaviour can be seen also in other parts of the world (in particular South America), as summarised in Figure 11.

The graph shows clearly the regions moving to the endemic stage (higher prevalence in 2004-2005 than 2011, as in North America) and those with higher prevalence in 2011 than 2004-2005 but in different stages: Western Europe has a lower difference (moving to stabilisation), Eastern Europe,

South America and Oceania have a higher difference (epidemic stage) and the epidemic stage is even more pronounced in Africa and Asia.

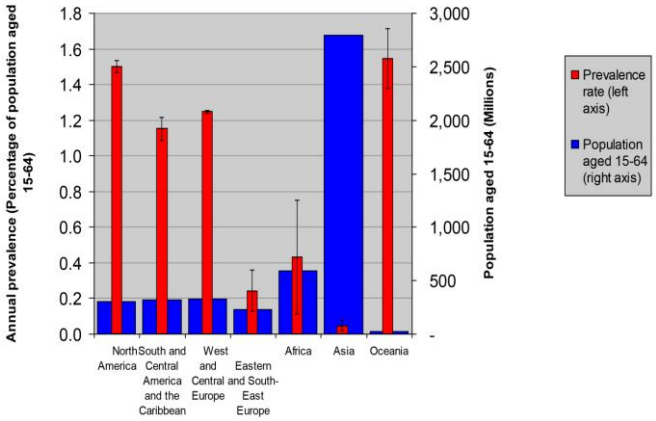
Figure 11. Trends in cocaine use in various regions and populations

Breakdown of number of cocaine users (past year), 2004-05 versus 2011



Source: UNODC, World Drug Report 2013 and previous years.

Breakdown of global population aged 15-64 and corresponding annual prevalence of cocaine use, 2011



Source: UNODC, World Drug Report 2013

Trends in Central and South America

Although cocaine is consumed worldwide, its production starts in South America. In the past, the general assumption was that cocaine was produced largely for export outside the region, but this no longer seems to be the case. Cocaine use is widespread across Latin America and the Caribbean, in addition to North America. Approximately half the cocaine users in the world are in the American hemisphere; of these, 70% are found in North America and 27% in South America. While cocaine use appears to be rather stable among high school students in the United States, in the few countries in South America that have trend data cocaine use among high school students is at best stable. In some South American countries, past year cocaine use has reached levels similar to those found in Europe. Of even greater concern are the rates of past month use, which are now higher in some South American and Caribbean countries than in the United States.

The increasing cocaine use in Brazil is acknowledged in the country's national programme launched in December 2011. The increase in seizures could also reflect the role of Brazil as a country of departure for cocaine trafficking across the Atlantic Ocean, as shown in Figure 3.

The Second Brazilian Alcohol and Drugs Survey (II BNADS) interviewed 4607 individuals aged 14 years and older from the Brazilian household population, including an over sample of 1157 adolescents (14 to 18 years old) between November 2011 and March 2012.The survey gathered information on alcohol, tobacco and illegal substances use as well as on risk factors for abuse and dependence.Last year consumption of crack-cocaine was 2.2% in the overall population excluding the elderly group. Lifetime and last year prevalence rate of snorted cocaine was 3.9% and 1.7%, respectively. Smoked cocaine use in Brazil was estimated in 1.5% for lifetime and 0.8% for last year use. Cocaine addiction was identified in 41.4% between users in the prior year.

The prevalence rates of snorted and smoked cocaine in Brazil suggests that the country is amongst the nations with greatest annual consumption rates becoming one of the biggest consumer markets of cocaine worldwide[7].

A recent pilot study (Santos Cruz et al. 2013) analysed the issue, as crack use constitutes a major problem in cities across Brazil. While existing data suggest that crack use is generally concentrated among disenfranchised young people with extensive health problems and crime involvement, large data gaps exist. To address this issue, the study aimed to assess key characteristics of young crack users (aged 18-24) in two Brazilian cities, Rio de Janeiro (south-east), where the epidemic started earlier and Salvador (north-east), where the epidemic started later. Assessments included an interviewer-administered questionnaire on key social, drug use, health and service use characteristics, as well as serological testing of HBV, HCV and HIV status, and were conducted anonymously between November 2010 and June 2011. The majority of participants were: male, with less than high school education, unstably housed (Rio only); gained income from legal or illegal work; arrested by police in past year (Salvador only); had numerous daily crack use episodes and shared paraphernalia (Salvador only); co-used alcohol, tobacco, cannabis and cocaine; had no injection history; rated physical and mental health as 'fair' or lower (Salvador only); had unprotected sex; were never HIV tested; were not HIV, HBV or HCV positive; and did not use existing social or health services, but desired access to crack user specific services.

The preliminary conclusion was: crack users in the two Brazilian sites featured extensive socio-economic marginalisation, crack and poly-drug use as well as sexual risk behaviours, and compromised health status. Social and health service utilisation is low, yet needs are high.

It is documented that the co-use of crack with cannabis is a common 'harm reduction' method among many crack users in South America; however, the combined intensive smoking patterns of these various substances may result in problematic (eg, pulmonary-bronchial) effects on users (Andrade et al. 2011, Haim et al. 1995, Restrepo et al. 2007).

Cocaine spread in Africa

The most striking new trend in cocaine trafficking in recent years has been the rising importance of Africa, notably of West and Central Africa, as a transit area for cocaine shipments to Europe. Seizures made in Africa rose from less than 1 mt over the 1998-2002 period to 15 mt in 2006. Most of the increase took place in 2006 and is still increasing in 2013 as shown in Figure 14 b. Criminal groups from West African countries continue to dominate the cocaine retail trade in a number of European countries. The cocaine traffic route to Europe passing through West African countries is increasing in importance (Figure 12).

Being transit countries also increases the local cocaine consumption in various African countries. While 11 African countries reported rising levels of cocaine use in 2001-02, this number increased to 14 over the 2005-06 period; in parallel, the number of African countries reporting falling levels of cocaine use fell from seven to two.

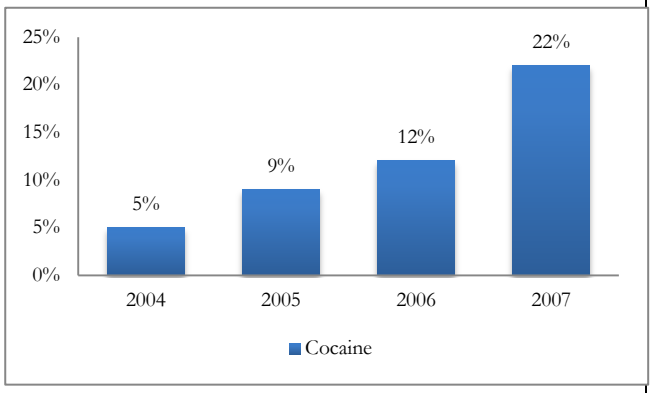
The prevalence rate in Kenya, while probably still lower than in Nigeria or South Africa, implies a sizeable consumer market of its own, and there are indications that East Africa may have acquired increased importance as a destination or as a transit region. The United Republic of Tanzania

[7] https://www.ncbi.nlm.nih.gov/pubmed/24455783.

reported seizures of 65 kg in 2010, a level which, although small, significantly exceeds those recorded in previous years.[8]

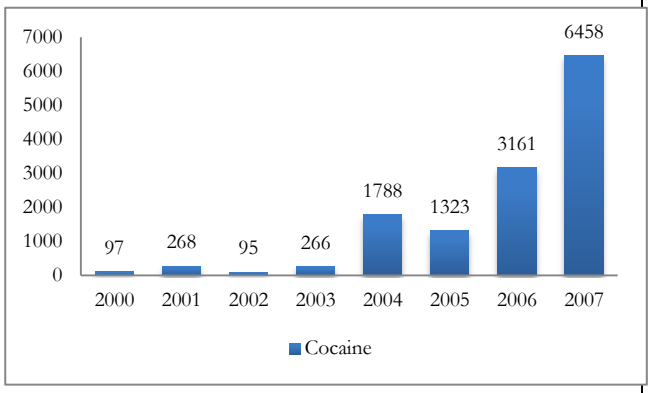
Figure 12. Changes in seizures due to starting West Africa routes

Proportion of individual cocaine seizures made in Europe that transited Africa, 2004-2007



Source: UNODC, Individual drug seizures database

Annual cocaine seizures in West Africa, 2000-2007



Source: UNODC *World Drug Report* 2007, and UNODC *Data for Africa* for 2006 and 2007 statistics

* preliminary data for 2006 based on available data as of November 2007

** from data collected by UNODC between January and November 2007

From Africa to Asia

The provenance of cocaine in East Africa is not clear, but in addition to West Africa, the Gulf region, itself a region with a limited but possibly growing market, has also emerged as a possible source. The United Arab Emirates and Saudi Arabia have both registered increased seizures of cocaine in recent years. Uganda, Poland and Thailand identified the United Arab Emirates as a transit country for seized cocaine reaching their territory in 2011. Qatar was also identified as a transit country by Japan, which has in turn increased its seizures of cocaine.

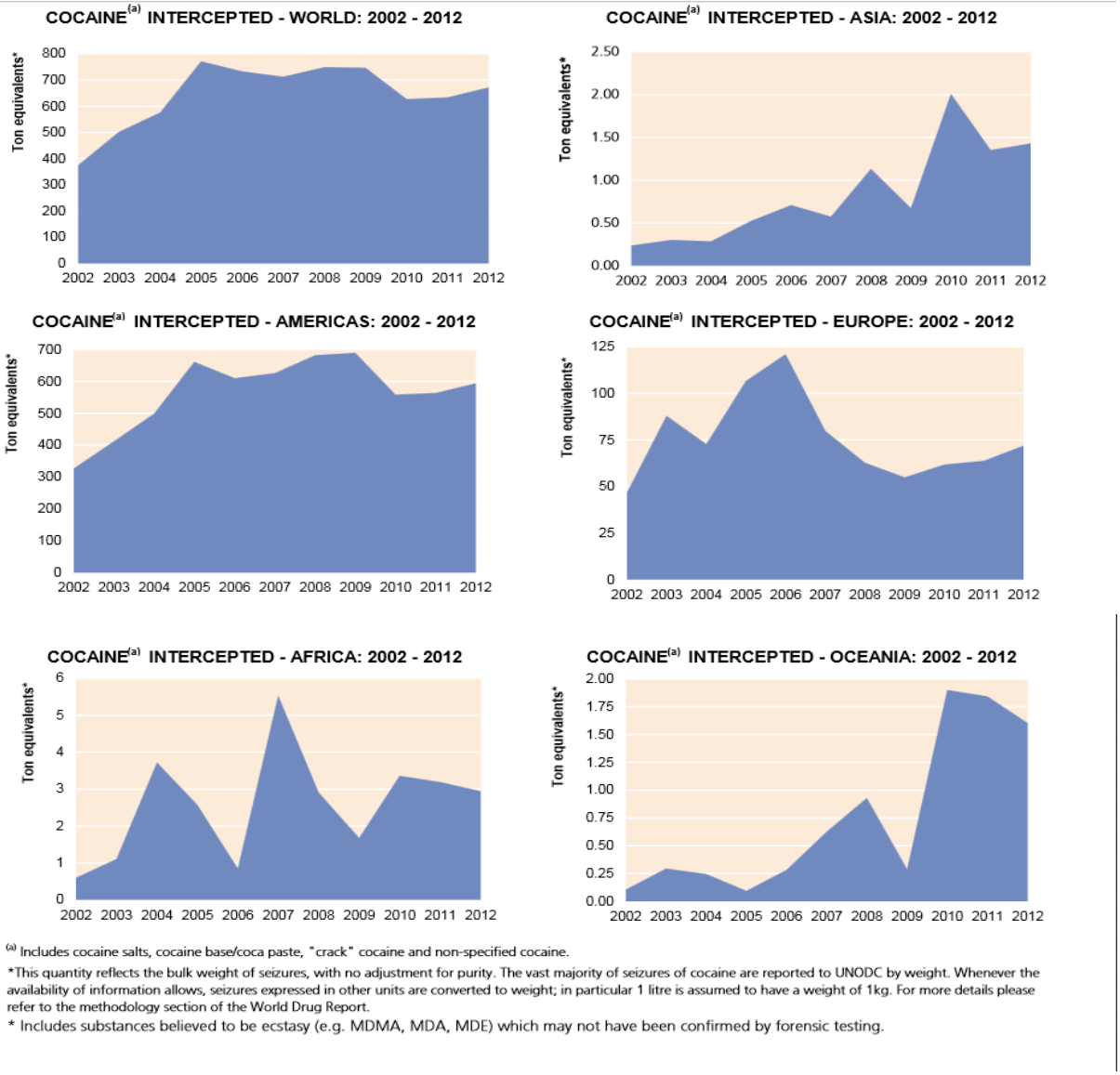
Among the markets with potential for growth of cocaine use, East and South-East Asia arguably present the greatest risk of expansion. Seizures in Hong Kong rose sharply to almost 600 kg in 2010 and more than 800 kg in 2011. The Philippines has also seized relatively large quantities of cocaine in recent years. Figure 13 shows the trends in cocaine interceptions all over the world.

Cocaine seizures maps are available on UNODC site and show the global spread of cocaine market [9] and the most recent maps are reported in Figure 14 (a and b).

[8] Some further qualitative and quantitative analyses can be found in the 2014 independent report of the West Africa Commission on Drugs: http://www.wacommissionondrugs.org/WACD_report_June_2014_english.pdf.

[9] http://www.unodc.org/unodc/search.html?q=cocaine+seizures&site=unodc&btnG=Search&site=unodc&proxyreload=1&sort=date%3AD%3AL%3Ad1&entqr=0&entqrm=0&ud=1

Figure 13. Cocaine interception in the world, showing the tendency for the market to expand eastwards



Source: UNODC *World Drug Report* 2014

Figure 14 a. Seizures of cocaine in 2012

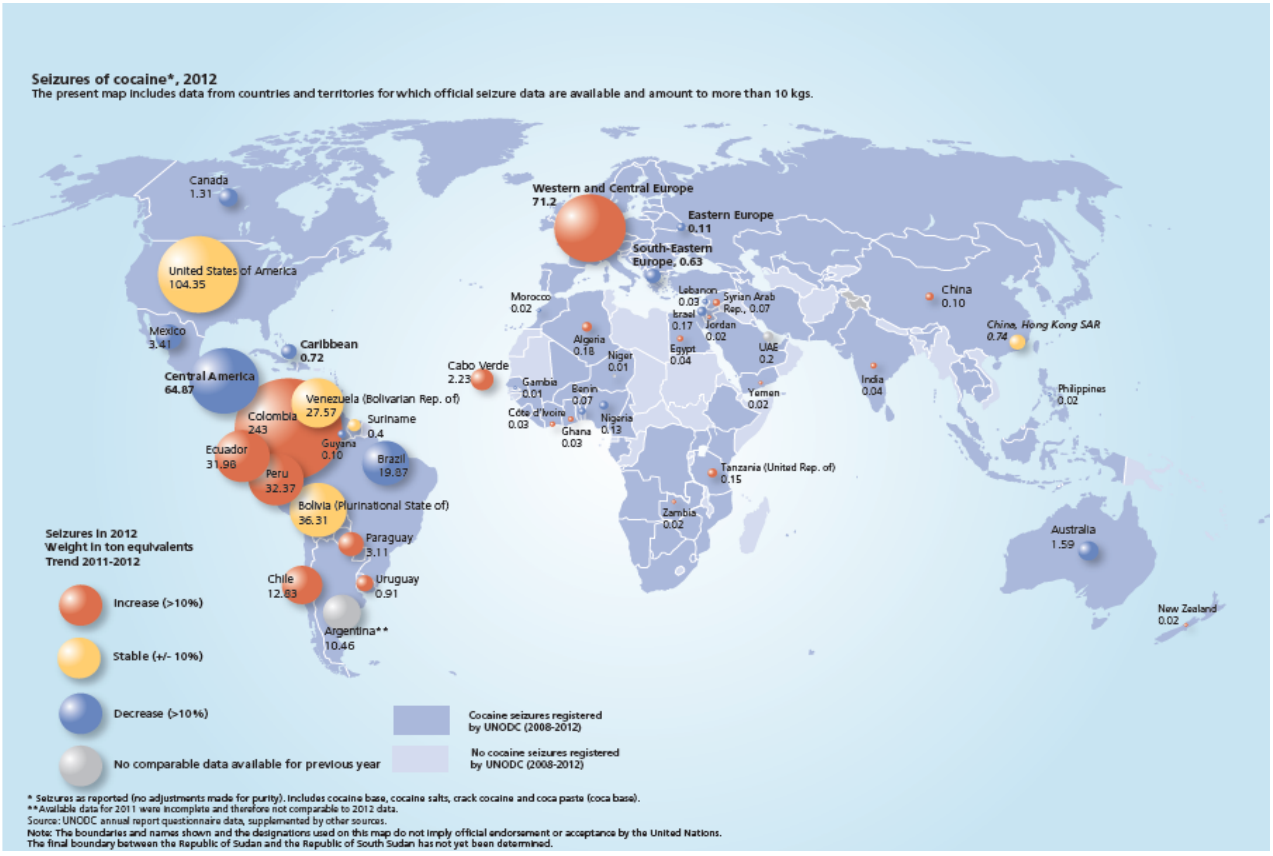
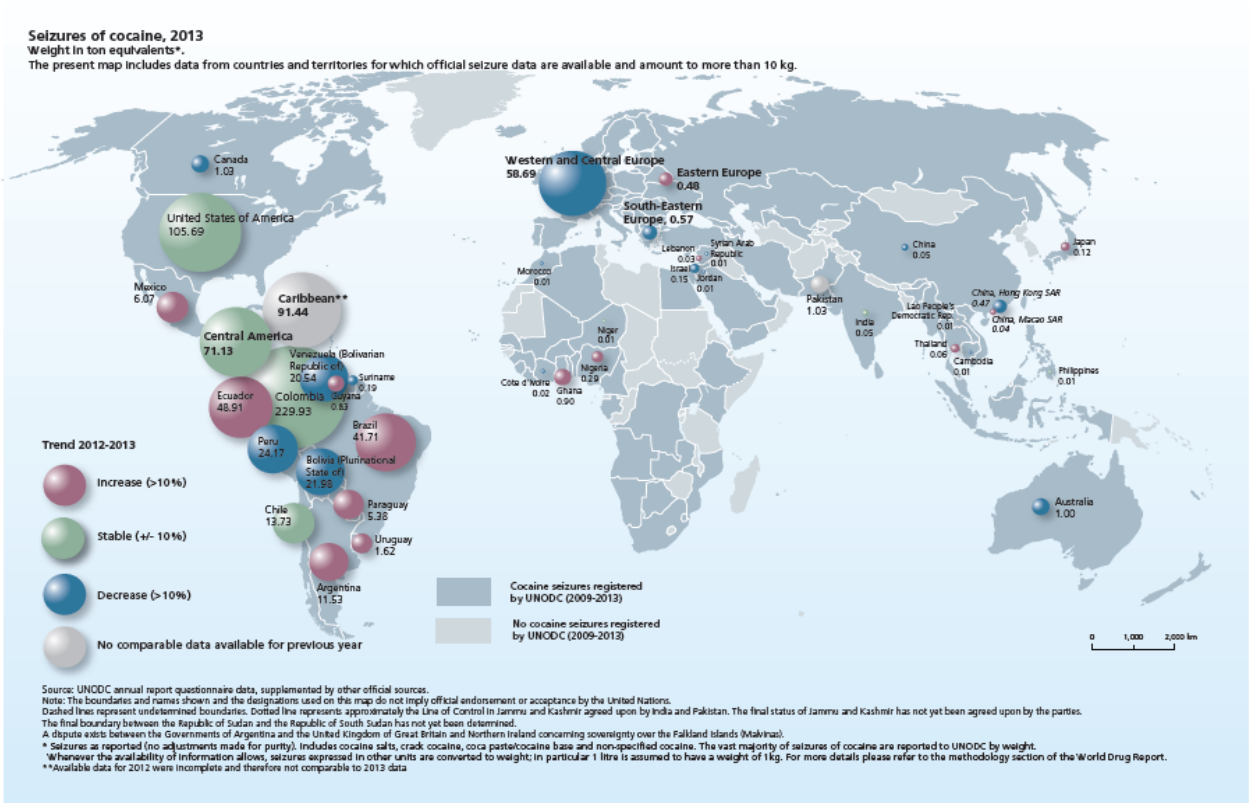


Figure 14 b. Seizures of cocaine 2013

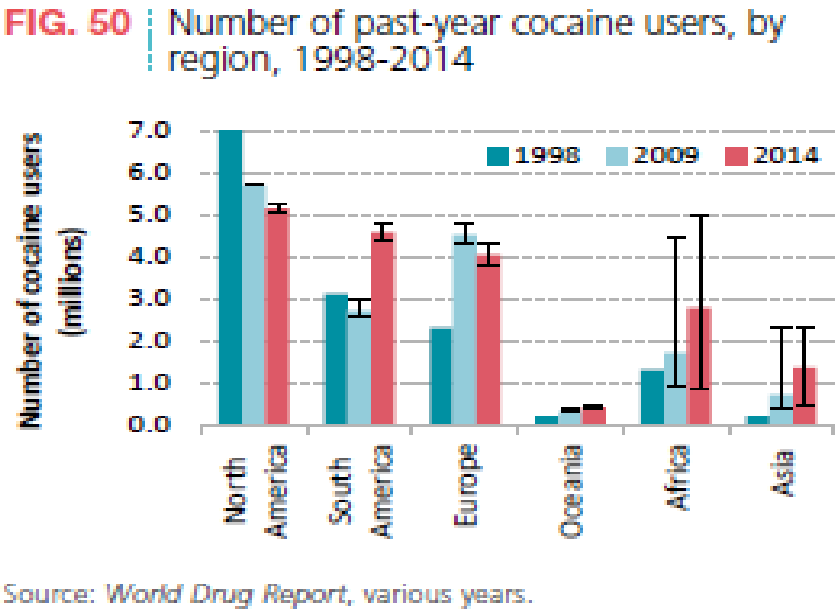


Conclusions

The cocaine market is still expanding, following what seems to be a clear 'regional commercial strategy' by traffickers. The differentiation of coca derivatives, with the creation of crack as a less expensive substance, can also be seen as a way to maintain and increase market shares. Africa, Asia and Oceania are the present expansion areas as can be read in Figure 15, but the countries of Eastern Europe have not yet reached peak levels and an endemic phase is probable in the near future.

It is quite clear that various drug policies applied in the five continents are quite ineffective and need to be analysed with a scientific and pragmatic approach, taking into account the economic results obtained by traffickers and criminal organisations more generally, with the serious unintended consequences – such as the impact on country competitiveness – that will be considered in our later chapter.

Figure 15. Epidemic phases in South America, Oceania, Africa and Asia, endemic in North America and European Union.



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